PRINTED: 05/23/2011 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES |                     |                                |                  |   |                | MB NO. 0938-0391 |
|--|---------------------|--------------------------------|------------------|---|----------------|------------------|
| STATEME                                  | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA     | (X2) MULTIPLE CO | ONSTRUCTION   | (X3) DATE      | SURVEY           |
| AND PLAN                                 | OF CORRECTION       | IDENTIFICATION NUMBER:         | A. BUILDING      | 00  | COMP           | LETED            |
|  |                     | 155287                         | B. WING          |   | 05/04/2        | 2011             |
|  |                     |                                |                  | ADDRESS, CITY, STATE, ZIP COD                               | <b>L</b><br>DE |                  |
| NAME OF                                  | PROVIDER OR SUPPLIE | R                              |                  | GRACE ST  |                |                  |
| RENSSE                                   | ELAER CARE CEN      | TER                            |                  | SELAER, IN47978   |                |                  |
| (X4) ID                                  | SUMMARY             | STATEMENT OF DEFICIENCIES      | ID               | PROVIDER'S PLAN OF CORRE                                    | CTION          | (X5)             |
| PREFIX                                   | (EACH DEFICIEN      | NCY MUST BE PERCEDED BY FULL   | PREFIX           | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APP | ULD BE         | COMPLETION       |
| TAG                                      | REGULATORY OF       | R LSC IDENTIFYING INFORMATION) | TAG              | DEFICIENCY)   |                | DATE             |
| F0000                                    |                     |                                |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | 1                   | or the Investigation of        | F0000            |   |                |                  |
|  | Complaint IN00      | 0089581.                       |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | Complaint IN00      | 0089581-Substantiated. No      |                  |   |                |                  |
|  | deficiencies rela   | ated to the allegation are     |                  |   |                |                  |
|  | cited.              |                                |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | Unrelated defici    | ency cited.                    |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | Survey dates: N     | May 3 & 4, 2011                |                  |   |                |                  |
|  |                     | •                              |                  |   |                |                  |
|  | Facility number     | : 000185                       |                  |   |                |                  |
|  | Provider numbe      |                                |                  |   |                |                  |
|  | AIM number: 1       |                                |                  |   |                |                  |
|  | All number.         | 00270040                       |                  |   |                |                  |
|  | Survey team:        |                                |                  |   |                |                  |
|  | 1 *                 | N TC                           |                  |   |                |                  |
|  | Janet Adams, R      |                                |                  |   |                |                  |
|  | Kathleen Vargas     | s, RN                          |                  |   |                |                  |
|  | C 1 1               |                                |                  |   |                |                  |
|  | Census bed type     | <del>)</del> :                 |                  |   |                |                  |
|  | SNF/NF: 99          |                                |                  |   |                |                  |
|  | Total: 99           |                                |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | Census payor ty     | pe:                            |                  |   |                |                  |
|  | Medicare: 16        |                                |                  |   |                |                  |
|  | Medicaid: 66        |                                |                  |   |                |                  |
|  | Other: 17           |                                |                  |   |                |                  |
|  | Total: 99           |                                |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | Sample: 9           |                                |                  |   |                |                  |
|  |                     |                                |                  |   |                |                  |
|  | This deficiency     | reflects state findings        |                  |   |                |                  |

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$ 

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2TCM11

Facility ID:

000185

TITLE

If continuation sheet

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETER        |  |   |         |             |
|--|--|---|--|--|---|---------|-------------|
| THIS TEXT  | or condition                           | 155287  | A. BUII<br>B. WIN  |  |   | 05/04/2 |             |
|  | PROVIDER OR SUPPLIER  LAER CARE CENT   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  1309 E GRACE ST RENSSELAER, IN47978 |  |   |         |             |
| (X4) ID  | SUMMARY S'                             | TATEMENT OF DEFICIENCIES  | 1  | ID   | PROVIDER'S PLAN OF CORRECTION   |         | (X5)        |
| PREFIX   | *                                      | CY MUST BE PERCEDED BY FULL   | PREFIX   |  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE                         | ΓE      | COMPLETION  |
| TAG  |  | ce with 410 IAC 16.2  | <u> </u>   | TAG  | DEFICIENCY)   |         | DATE        |
| E0222  | Quality review comp<br>Faulkner, RN    | pleted on May 5, 2011 by Bev  nsure that the resident                             |  |  |   |         |             |
| F0323<br>SS=D  | environment remains hazards as is poss | ins as free of accident<br>sible; and each resident<br>supervision and assistance |  |  | May 47th COMAThia Dlay of   |         | 0.7/20/20/4 |
|  | Based on                               | observation,  | F0   | 323  | May 17th, 2011This Plan of Correction is submitted as   |         | 05/20/2011  |
|  | record rev                             | riew, and   |  |  | required under Federal and S regulation and statues applic                                    | able    |             |
|  | interview,                             | the facility  |  |  | to long term care providers. Plan of Correction does not                                      |         |             |
|  | failed to p                            | rovide  |  |  | constitute an admission of lia on the part of the facility, and                               | 1       |             |
|  | adequate s                             | supervision to  |  |  | such liability is hereby specif denied. The submission of the                                 | -       |             |
|  | prevent ac                             | ccidents related  |  |  | plan does not constitute an agreement by the facility that                                    |         |             |
|  | to alarms                              | not in place  |  |  | surveyors' findings or conclu-  | s       |             |
|  | correctly f                            | for 2 of 6  |  |  | constitute a deficiency, or that scope or severity regarding a the deficiencies cited are cor | any of  |             |
|  | residents v                            | with alarms in  |  |  | applied1.Corrective action accomplished for Resident  | rectly  |             |
|  | the sample                             | e of 9, grip  |  |  | affected by the alleged   | г.      |             |
|  | strips not                             | in place for 1  |  |  | deficient practice: Resident<br>Staff educated by SDC to no                                   | t       |             |
|  | of 3 reside                            | ents with   |  |  | leave resident unattended in bathroom. Dycem was replaced any whoelebair and auto broken      | ced     |             |
|  | orders for                             | grip strips in  |  |  | on wheelchair and auto brake<br>were discontinued on chair d                                  | ue to   |             |
|  | the sample                             | e of 9, Dycem   |  |  | decline in mobility. Plan of care updated. Resident B: Grippy                                 |         |             |
|  | not in plac                            | ce for 1 of 3   |  | strips placed in front of stationary chair. Plan of care updated.Resident D: Care plan |   |         |             |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2TCM11 Facility ID:

000185

If continuation sheet

Page 2 of 18

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | (X2) M                       | ULTIPLE CC | ONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                                     |            |
|--|----------------------|------------------------------|------------|--|---|------------|
| ANDILAN  | or connection        | 155287                       |            | LDING  | 00  | 05/04/2011 |
|  |                      | .0020                        | B. WIN     |  | ADDRESS, CITY, STATE, ZIP CODE                                    | 00.02011   |
| NAME OF I  | PROVIDER OR SUPPLIER |                              |            |  | GRACE ST  |            |
| RENSSE   | LAER CARE CENT       | ER                           |            | 1  | SELAER, IN47978   |            |
| (X4) ID  | SUMMARY S            | TATEMENT OF DEFICIENCIES     | _          | ID   |   | (X5)       |
| PREFIX   |                      | CY MUST BE PERCEDED BY FULL  |            | PREFIX   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE   | COMPLETION |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |            | TAG  | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                  | DATE       |
|  | residents v          | with orders for              |            |  | amended to include his jacke<br>an acceptable place to clip       | et as      |
| Dycem in the sample of   |                      |                              |            | wheelchair alarm due to him wearing a jacket much of the |   |            |
|  |                      | hair auto locks              |            |  | time. 2. How Facility review                                      | I          |
|  |                      |                              |            |  | affected by the same allege                                       | ed         |
|  | not in piac          | ce for 1 of 1                |            |  | deficient practice.Care guid                                      | le         |
|  | residents v          | with orders for              |            |  | rounds are done Monday thr<br>Friday by departmental staff        | to         |
|  | wheelchai            | r auto locks in              |            |  | review fall prevention equipment in place. Facility identified a  |            |
|  | the sample           | e of 9                       |            |  | residents that had Dycem, g strips, alarms and auto lock          |            |
|  | *                    |                              |            |  | brakes. Audit completed to v                                      |            |
|  | The facilit          | ty also failed to            |            |  | that mentioned protective   |            |
|  | ensure ade           | equate                       |            |  | equipment was in place by umanagers.3. A systemic characteristics |            |
|  | supervisio           | on was                       |            |  | the facility has made to ens                                      |            |
|  | provided 1           |                              |            |  | does not occur.New orders reviewed Monday through F               |            |
|  | •                    |                              |            |  | during change of condition b                                      | y          |
|  | supervisin           | ng a resident on             |            |  | IDON, Unit Managers, SDC MDS to ensure all new order              |            |
|  | the toilet f         | for 1 of 1                   |            |  | received for fall prevention                                      | 3          |
|  | ا معمالم ا           | 41. a a a a a a 1 a          |            |  | equipment have been   |            |
|  | residents i          | in the sample                |            |  | implemented on care guides care plans and TAR. A physi            |            |
|  | of 9 who s           | sustained a fall             |            |  | check of the intervention is of to ensure device is in            | I          |
|  | from the t           | oilet.                       |            |  | place.Clinical staff will be                                      |            |
|  |                      |                              |            |  | in-serviced on protocol relate                                    | ed to      |
|  | (Residents           | s #B, #D, and                |            |  | resident having wheelchair alarms and toileting assistan          | ice.       |
|  | #E)                  |                              |            |  | Department Heads will be  |            |
|  | #L)                  |                              |            | inserviced on care guide use                             |   |            |
|  |                      |                              |            |  | rounds by SDC and/or nursil administration. Clinical staff        | -          |
|  | Findings i           | nclude.                      |            |  | be in serviced on care guide                                      | use        |
|  |                      | iiviuuv.                     |            |  | and rounds by SDC to ensur  | e          |
|  |                      |                              |            |  | equipment in place.Staff  |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  |        | NSTRUCTION 00   | COMPLETED  |   |
|--|--|--|--------|-----------------|--|---|
|  |  | 155287   |        | LDING           |  | 05/04/2011  |
|  | 1. During observation 8:50 a.m., QMA #1 with transferring from the with the bed. QMA #1 tresident upon the bed of the was lifted Dycem (the prevent short of or under wheelchair wheelchair was lifted by the bed of or under wheelchair wheelchair was lifted by the bed of or under wheelchair wheelchair was lifted by the bed by the b | tatement of deficiencies cy must be perceded by full list identifying information)  an on on 5/4/11 at CNA #2 and were ag Resident #E wheelchair to CNA#2 and transferred the sing a gait belt ed. After the was in bed, the at top of the wheelchair. There was no nin pad to ipping) on top or the | B. WIN | STREET A 1309 E | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Development Coordinator/Nursing Administration and rehab se manager will educate nursin staff and therapist on above system during orientation an indicated for compliance. 4. I corrective actions will be monitored to ensure that alleged deficient practice we not reoccur. Nursing Administration will monitor/ all residents with a WC alarr dycem, auto breaks and grip strips. Audits will be conduct Mon through Fri 1X per day weeks then 3X per week for weeks then weekly for 4 week compliance threshold of 100 achieved for 1 month following the initial 12 weeks, the QA committee will determine if for audits and or frequency of a are necessary. 5. By what of the systemic changes will completed. Date of compliance is May 20th, 2011. | (X5) COMPLETION DATE  Prvices ag and as How  will audit m, b ted for 4 4 eks. If 0% is ing further audits date be |
|  |  |  |        |                 |  |   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287 |                      | ĺ   | LDING   | NSTRUCTION 00       | (X3) DATE<br>COMPI<br>05/04/2   | LETED |                            |
|--|----------------------|---|---------|---------------------|---|-------|----------------------------|
|  | PROVIDER OR SUPPLIER |   | p. wiiv | 1309 E              | ADDRESS, CITY, STATE, ZIP CODE<br>GRACE ST<br>ELAER, IN47978  |       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | E     | (X5)<br>COMPLETION<br>DATE |
|  | pad under            | the cushion.  |         |                     |   |       |                            |
|  | There was no Dycem   |   |         |                     |   |       |                            |
|  | under the            | sensor pad.   |         |                     |   |       |                            |
|  | There wer            | e no auto lock  |         |                     |   |       |                            |
|  | brakes on            | the   |         |                     |   |       |                            |
|  | wheelchai            | r.  |         |                     |   |       |                            |
|  |                      |   |         |                     |   |       |                            |
|  | On 5/4/11            | at 9:05 a.m.,   |         |                     |   |       |                            |
|  | the Unit D           | Director entered  |         |                     |   |       |                            |
|  | the reside           | nt's room. The  |         |                     |   |       |                            |
|  | Unit Direc           | ctor indicated  |         |                     |   |       |                            |
|  | there were           | e no auto locks   |         |                     |   |       |                            |
|  | on the resi          | ident's   |         |                     |   |       |                            |
|  | wheelchai            | r. When   |         |                     |   |       |                            |
|  | interviewe           | ed at this time,  |         |                     |   |       |                            |
|  | the Unit D           | Director  |         |                     |   |       |                            |
|  | indicated            | the resident  |         |                     |   |       |                            |
|  | recently re          | eceived a new   |         |                     |   |       |                            |
|  | wheelchai            | r from Hospice  |         |                     |   |       |                            |
|  | and auto 1           | ocks were not   |         |                     |   |       |                            |
|  |                      |   |         |                     |   |       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155287 |                     | LDING   | NSTRUCTION  00      | (X3) DATE S<br>COMPL<br>05/04/20   | ETED |                            |
|--|---------------------|---|---------------------|--|------|----------------------------|
| NAME OF I  | PROVIDER OR SUPPLIE | ₹   | 1                   | ADDRESS, CITY, STATE, ZIP CODE  GRACE ST   |      |                            |
| RENSSE   | ELAER CARE CENT     | ΓER   | 1                   | ELAER, IN47978   |      |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΓE   | (X5)<br>COMPLETION<br>DATE |
|  | in place.           | The Unit  |                     |  |      |                            |
|  | Director i          | ndicated the  |                     |  |      |                            |
|  | Dycem sh            | ould have been  |                     |  |      |                            |
|  | in place.           |   |                     |  |      |                            |
|  |                     |   |                     |  |      |                            |
|  | The recor           | d for resident  |                     |  |      |                            |
|  | #E was re           | eviewed on  |                     |  |      |                            |
|  | 5/3/11 at           | 10:15 a.m. The  |                     |  |      |                            |
|  | resident's          | diagnoses   |                     |  |      |                            |
|  | included,           | but were not  |                     |  |      |                            |
|  | limited to          | , mild  |                     |  |      |                            |
|  | dementia,           | falls, high   |                     |  |      |                            |
|  | blood pre           | ssure, atrial   |                     |  |      |                            |
|  | fibrillation        | n (an irregular   |                     |  |      |                            |
|  |                     | and diabetes  |                     |  |      |                            |
|  | mellitus.           | ,,  |                     |  |      |                            |
|  |                     |   |                     |  |      |                            |
|  | Review o            | f the 5/11  |                     |  |      |                            |
|  | Physician           |   |                     |  |      |                            |
|  |                     | t indicated there   |                     |  |      |                            |
|  |                     |   |                     |  |      |                            |

000185

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155287 |  | (X2) MU<br>A. BUII<br>B. WIN  | LDING | 00                  | (X3) DATE<br>COMPI<br>05/04/2                                | LETED |                            |
|---|--|---|-------|---------------------|--|-------|----------------------------|
|   | PROVIDER OR SUPPLIER   |   | '     | 1309 E              | ADDRESS, CITY, STATE, ZIP CODE<br>GRACE ST<br>ELAER, IN47978 |       |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |       | ID<br>PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIATE                          |       | (X5)<br>COMPLETION<br>DATE |
|   | were Phys  | sician's orders   |       |                     |  |       |                            |
|   | for the resident to have                                     |   |       |                     |  |       |                            |
|   | auto locks   | s to the  |       |                     |  |       |                            |
|   | wheelchai  | r and a Dycem   |       |                     |  |       |                            |
|   | under the  | wheelchair  |       |                     |  |       |                            |
|   | cushion.   | A Physician's   |       |                     |  |       |                            |
|   | order was  | written on  |       |                     |  |       |                            |
|   | 1/28/11 fc   | or the resident   |       |                     |  |       |                            |
|   | to have a j  | personal alarm  |       |                     |  |       |                            |
|   | to the whe   | eelchair.   |       |                     |  |       |                            |
|   | The resident's current care plans were reviewed. A care plan |   |       |                     |  |       |                            |
|   | initiated o  | •   |       |                     |  |       |                            |
|   |  | the resident  |       |                     |  |       |                            |
|   |  | x for falls and   |       |                     |  |       |                            |
|   | new injuri   |   |       |                     |  |       |                            |
|   |  | mobility and  |       |                     |  |       |                            |
|   | •  | The care plan   |       |                     |  |       |                            |

000185

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155287 |                      | A. BUILDING   | 00                  | COI  | MPLETED 4/2011                      |                            |
|---|----------------------|---|---------------------|--|-------------------------------------|----------------------------|
|   | PROVIDER OR SUPPLIER |   | 1309                | ET ADDRESS, CITY, STATE, DE GRACE ST ISSELAER, IN47978           | ZIP CODE                            |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|   | was last u           | pdated with a   |                     |  |                                     |                            |
|   | goal date            | of 5/20/11.   |                     |  |                                     |                            |
|   | Care plan            | approaches  |                     |  |                                     |                            |
|   | included f           | for the resident  |                     |  |                                     |                            |
|   | to have au           | to lock brakes  |                     |  |                                     |                            |
|   | on the wh            | eelchair. The   |                     |  |                                     |                            |
|   | 5/4/11 car           | e assignment  |                     |  |                                     |                            |
|   | sheets for           | resident were   |                     |  |                                     |                            |
|   | reviewed             | on 5/4/11 at  |                     |  |                                     |                            |
|   | 9:05 a.m.            | The   |                     |  |                                     |                            |
|   | assignmer            | nt sheet  |                     |  |                                     |                            |
|   | indicated            | there was to be   |                     |  |                                     |                            |
|   | Dycem in             | the resident's  |                     |  |                                     |                            |
|   | wheelchai            | r and the   |                     |  |                                     |                            |
|   | resident w           | as to have a  |                     |  |                                     |                            |
|   | pressure r           | educing   |                     |  |                                     |                            |
|   | cushion in           | the high back   |                     |  |                                     |                            |
|   | wheelchair with auto |   |                     |  |                                     |                            |
|   | lock brake           | es.   |                     |  |                                     |                            |
|   |                      |   |                     |  |                                     |                            |
|   |                      |   |                     |  |                                     |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155287 |                      | (X2) M<br>A. BUII<br>B. WIN   | LDING | NSTRUCTION 00       | (X3) DATE COMPL  | ETED |                            |
|---|----------------------|---|-------|---------------------|--|------|----------------------------|
|   | PROVIDER OR SUPPLIER |   |       | 1309 E              | ADDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978   |      |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |
|   | The 2/25/            | 11 Minimum  |       |                     |  |      |                            |
|   | Data Set (           | MDS)  |       |                     |  |      |                            |
|   | significan           | t change  |       |                     |  |      |                            |
|   | assessmen            | nt indicated the  |       |                     |  |      |                            |
|   | resident B           | SIMS  |       |                     |  |      |                            |
|   | (assessme            | nt of cognitive   |       |                     |  |      |                            |
|   | patterns) s          | score was 10.   |       |                     |  |      |                            |
|   | A score of           | f 10-12   |       |                     |  |      |                            |
|   | indicates t          | the resident's  |       |                     |  |      |                            |
|   | cognitive            | status was  |       |                     |  |      |                            |
|   | moderatel            | y impaired.   |       |                     |  |      |                            |
|   | The assess           | sment also  |       |                     |  |      |                            |
|   | indicated            | the resident  |       |                     |  |      |                            |
|   | required e           | xtensive  |       |                     |  |      |                            |
|   | assistance           | of two staff  |       |                     |  |      |                            |
|   | members              | for transfers   |       |                     |  |      |                            |
|   | and toilet           | use. The Care   |       |                     |  |      |                            |
|   | Area Asse            | essment   |       |                     |  |      |                            |
|   | completed            | l with the MDS  |       |                     |  |      |                            |
|   | assessmer            | nt indicated the  |       |                     |  |      |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155287 |                      | (X2) MU<br>A. BUIL<br>B. WINC   | DING   | onstruction 00      | (X3) DATE :<br>COMPL<br>05/04/2   | ETED |                            |
|--|----------------------|---|--|---------------------|---|------|----------------------------|
|  | PROVIDER OR SUPPLIER |   | STREET ADDRESS, CITY, STATE, ZIP CODE  1309 E GRACE ST RENSSELAER, IN47978 |                     |   |      |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 1  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE  | (X5)<br>COMPLETION<br>DATE |
|  | resident h           | ad multiple   |  |                     |   |      |                            |
|  | falls and v          | vas at high risk  |  |                     |   |      |                            |
|  | for falls.           |   |  |                     |   |      |                            |
|  | A 1/27/11            | Fall Risk   |  |                     |   |      |                            |
|  | Evaluation           | n indicated the   |  |                     |   |      |                            |
|  | resident h           | ad 1-2 falls in   |  |                     |   |      |                            |
|  | the last 90          | days, had a   |  |                     |   |      |                            |
|  | history of           | a hip fracture,   |  |                     |   |      |                            |
|  | and decrea           | ased lower  |  |                     |   |      |                            |
|  | extremity            | strength. The   |  |                     |   |      |                            |
|  | evaluation           | also indicated  |  |                     |   |      |                            |
|  | the reside           | nt received   |  |                     |   |      |                            |
|  | anti-depre           | essant  |  |                     |   |      |                            |
|  | medication           | n, medication   |  |                     |   |      |                            |
|  | to treat high        | gh blood  |  |                     |   |      |                            |
|  | pressure, a          | and   |  |                     |   |      |                            |
|  | medication           | ns for diabetes   |  |                     |   |      |                            |
|  | mellitus.            | The evaluation  |  |                     |   |      |                            |
|  | indicated            | the resident's  |  |                     |   |      |                            |

000185

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155287 |                      |   | LDING   | NSTRUCTION 00       | (X3) DATE<br>COMPI<br>05/04/2   | LETED |                            |
|---|----------------------|---|---------|---------------------|---|-------|----------------------------|
|   | PROVIDER OR SUPPLIER |   | p. wiiv | 1309 E              | ADDRESS, CITY, STATE, ZIP CODE<br>GRACE ST<br>BELAER, IN47978   |       |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE |
|   | last fall w          | as 1/22/11.   |         |                     |   |       |                            |
|   | The reside           | ent's total score   |         |                     |   |       |                            |
|   | was 22 , v           | which indicated   |         |                     |   |       |                            |
|   | the reside           | nt was at high  |         |                     |   |       |                            |
|   | risk for fa          | lls.  |         |                     |   |       |                            |
|   |                      |   |         |                     |   |       |                            |
|   | The 2/201            | 1 Nurses'   |         |                     |   |       |                            |
|   | Notes wer            | e reviewed.   |         |                     |   |       |                            |
|   | An entry i           | made on 2/7/11  |         |                     |   |       |                            |
|   | at 7:40 a.r          | n., indicated   |         |                     |   |       |                            |
|   | the Nurse            | was called to   |         |                     |   |       |                            |
|   | the reside           | nt's room by a  |         |                     |   |       |                            |
|   | family me            | ember who   |         |                     |   |       |                            |
|   | stated they          | y heard a noise   |         |                     |   |       |                            |
|   | and noted            | the resident  |         |                     |   |       |                            |
|   | was on the           | e floor. The  |         |                     |   |       |                            |
|   | resident w           | as sitting on   |         |                     |   |       |                            |
|   | her buttoc           | k resting her   |         |                     |   |       |                            |
|   | back on the          | ne bathroom   |         |                     |   |       |                            |
|   | door and t           | the resident  |         |                     |   |       |                            |
|   |                      |   |         |                     |   |       |                            |

|           |                          | (X2) M                        | ULTIPLE CO | ONSTRUCTION | (X3) DATE S<br>COMPLE   |          |            |
|-----------|--------------------------|-------------------------------|------------|-------------|---|----------|------------|
| AND PLAN  | OF CORRECTION            | IDENTIFICATION NUMBER: 155287 | A. BUI     |             | 00  | 05/04/20 |            |
| NAME OF E | PROVIDER OR SUPPLIER     |                               | B. WIN     |             | ADDRESS, CITY, STATE, ZIP CODE  |          |            |
|           | LAER CARE CENT           |                               |            | 1           | GRACE ST<br>ELAER, IN47978  |          |            |
| (X4) ID   |                          | TATEMENT OF DEFICIENCIES      | 1          | ID          | ELAEK, IN47970  | 1        | (X5)       |
| PREFIX    |                          | CY MUST BE PERCEDED BY FULL   |            | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | JTE      | COMPLETION |
| TAG       |                          | LSC IDENTIFYING INFORMATION)  | <u> </u>   | TAG         | DEFICIENCY)   |          | DATE       |
|           | stated she was "tired of |                               |            |             |   |          |            |
|           | sitting on               | the stool."                   |            |             |   |          |            |
|           |                          |                               |            |             |   |          |            |
|           | An IDT                   |                               |            |             |   |          |            |
|           | (Interdisci              | iplinary team)                |            |             |   |          |            |
|           | note was o               | completed on                  |            |             |   |          |            |
|           | 2/8/11. T                | The IDT note                  |            |             |   |          |            |
|           | indicated                | the team met to               |            |             |   |          |            |
|           | review the               | e resident's fall             |            |             |   |          |            |
|           | on 2/7/11.               | The note                      |            |             |   |          |            |
|           | indicated                | the resident                  |            |             |   |          |            |
|           | was found                | l on the floor                |            |             |   |          |            |
|           | and stated               | she was trying                |            |             |   |          |            |
|           | to get off               | the toilet. The               |            |             |   |          |            |
|           | investigat               | ion indicated a               |            |             |   |          |            |
|           | CNA left                 | the resident on               |            |             |   |          |            |
|           | the toilet u             | unassisted.                   |            |             |   |          |            |
|           |                          |                               |            |             |   |          |            |
|           | When inte                | erviewed on                   |            |             |   |          |            |
|           | 5/4/11 at 1              | 11:10 a.m., the               |            |             |   |          |            |
|           |                          |                               |            |             |   |          |            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287 |  | LDING               | NSTRUCTION  00  | (X3) DATE SI<br>COMPLE<br><b>05/04/2</b> 0 | TED                        |
|--|--|--|--|---------------------|---|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER                     |  |  | •                                      |                     | DDRESS, CITY, STATE, ZIP CODE   | !  |                            |
| RENSSELAER CARE CENTER                           |  |  | 1309 E GRACE ST<br>RENSSELAER, IN47978 |                     |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | acting Director of   |  |  |                     |   |  |                            |
|  | Nursing in   | ndicated the   |  |                     |   |  |                            |
|  | resident w   | vas on the   |  |                     |   |  |                            |
|  | Falling St   | ar Program.  |  |                     |   |  |                            |
|  | When inte  | erviewed on  |  |                     |   |  |                            |
|  | 5/4/11 at 2  | 2:20 p.m., the   |  |                     |   |  |                            |
|  | Assistant Director of  |  |  |                     |   |  |                            |
|  | Nursing indicated it was   |  |  |                     |   |  |                            |
|  | the facility   | y protocol not   |  |                     |   |  |                            |
|  | to leave residents who   |  |  |                     |   |  |                            |
|  | were at ris  | sk for falls   |  |                     |   |  |                            |
|  | unattended in the  |  |  |                     |   |  |                            |
|  | bathroom.  |  |  |                     |   |  |                            |
|  |  |  |  |                     |   |  |                            |
|  |  |  |  |                     |   |  |                            |
|  |  | vas observed on 5/3/11 at                                |  |                     |   |  |                            |
|  |  | sident was seated in a in her room. There were           |  |                     |   |  |                            |
|  | 1  | on the floor in front of the                             |  |                     |   |  |                            |
|  |  | ary chair. During vations on 5/3/11 at 11:05             |  |                     |   |  |                            |
|  |  | and 3:30 p.m., the                                       |  |                     |   |  |                            |
|  | resident was sea   | ted in the stationary chair                              |  |                     |   |  |                            |
|  | in her room, thei  | re were no grippy strips                                 |  |                     |   |  |                            |

| STATEMENT OF DEFICIENCIES    |  | X1) PROVIDER/SUPPLIER/CLIA  | (:  | (X2) MULTIPLE CONSTRUCTION |                                 |                   |   | (X3) DATE SURVEY |             |  |
|------------------------------|--|-----------------------------|-----|----------------------------|---------------------------------|-------------------|---|------------------|-------------|--|
| AND PLAN OF CORRECTION       |  | IDENTIFICATION NUMBER:      | 4   | A. BUILD                   | oing 00                         |                   |   | COMPLETED        |             |  |
|                              |  | 155287                      | E   | B. WING                    |                                 |                   |   | 05/04/2          | 011         |  |
| NAME OF PROVIDER OR SUPPLIER |  |                             |     |                            | STREET A                        | DDRESS, CITY, STA | ATE, ZIP CODE                               |                  |             |  |
| NAME OF P                    | NO VIDER OR SUPPLIER   |                             |     |                            | 1309 E                          | GRACE ST          |   |                  |             |  |
| RENSSELAER CARE CENTER       |  |                             |     |                            | RENSS                           | ELAER, IN4797     | '8  |                  |             |  |
| (X4) ID                      | SUMMARY STATEMENT OF DEFICIENCIES  |                             |     |                            | ID PROVIDER'S PLAN OF CORRECTIO |                   | PLAN OF CORRECTION                          | (X5)             |             |  |
| PREFIX                       | (EACH DEFICIENC  | CY MUST BE PERCEDED BY FULL |     |                            |                                 | (EACH CORRECTIV   | VE ACTION SHOULD BE<br>ED TO THE APPROPRIAT | E                | COMPLETION  |  |
| TAG                          | REGULATORY OR  | LSC IDENTIFYING INFORMATION | )   |                            | TAG                             |                   | FICIENCY)                                   | DATE             |             |  |
|                              | on the floor in fro  | ont of the chair.           |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              | On 5/4/11 at 8:30  | a.m., the resident was      |     |                            |                                 |                   |   |                  |             |  |
|                              | observed seated i  | in the stationary chair in  |     |                            |                                 |                   |   |                  |             |  |
|                              | her room. There  | were no grippy strips on    |     |                            |                                 |                   |   |                  |             |  |
|                              | the floor in front   | of her. Further             |     |                            |                                 |                   |   |                  |             |  |
|                              |  | cated the sensor alarm      |     |                            |                                 |                   |   |                  |             |  |
|                              |  | lent was sitting on was     |     |                            |                                 |                   |   |                  |             |  |
|                              | not connected to   |                             |     |                            |                                 |                   |   |                  |             |  |
|                              | not connected to   | the alarm box.              |     |                            |                                 |                   |   |                  |             |  |
|                              | Interview with L   | PN #1 on 5/4/11 at 8:30     |     |                            |                                 |                   |   |                  |             |  |
|                              |  | nere were no grippy strips  |     |                            |                                 |                   |   |                  |             |  |
|                              | •  | ont of the resident's       |     |                            |                                 |                   |   |                  |             |  |
|                              |  | and the sensor alarm pad    |     |                            |                                 |                   |   |                  |             |  |
|                              | •  | -                           |     |                            |                                 |                   |   |                  |             |  |
|                              |  | ed to the alarm box. LPN    |     |                            |                                 |                   |   |                  |             |  |
|                              |  | sensor alarm pad should     |     |                            |                                 |                   |   |                  |             |  |
|                              |  | the alarm box and also      |     |                            |                                 |                   |   |                  |             |  |
|                              | indicated there sh   | hould be grippy strips on   |     |                            |                                 |                   |   |                  |             |  |
|                              | the floor.   |                             |     |                            |                                 |                   |   |                  |             |  |
|                              | TEI 1.C D  | · 1 . //D · · 1             |     |                            |                                 |                   |   |                  |             |  |
|                              |  | esident #B was reviewed     |     |                            |                                 |                   |   |                  |             |  |
|                              |  | p.m. The resident had       |     |                            |                                 |                   |   |                  |             |  |
|                              | •  | cluded, but were not        |     |                            |                                 |                   |   |                  |             |  |
|                              | limited to, hypert   | tension (high blood         |     |                            |                                 |                   |   |                  |             |  |
|                              | pressure), anemia  | a and dementia.             |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  | "Interdisciplinary          |     |                            |                                 |                   |   |                  |             |  |
|                              | •  | was reviewed. There was     |     |                            |                                 |                   |   |                  |             |  |
|                              | a note, dated 2/5/11 at 3 p.m., that indicated the resident fell from the stationary chair on 2/3/11. Further review of the "Interdisciplinary Progress Notes" indicated a progress note, dated 2/14/11 at |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  |                             |     |                            |                                 |                   |   |                  |             |  |
|                              |  | ted the resident fell on    |     |                            |                                 |                   |   |                  |             |  |
| FORM CMS-2:                  | 567(02-99) Previous Version  |                             | 2TC | M11                        | Facility I                      | D: 000185         | If continuation sh                          | neet Pa          | ge 14 of 18 |  |

| AND PLAN OF CORRECTION IDI    |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:    |         |                      | INSTRUCTION 00   |            | X3) DATE SURVEY<br>COMPLETED |  |
|-------------------------------|--|--|---------|----------------------|--|------------|------------------------------|--|
|                               |  | 155287   |         | A. BUILDING  B. WING |  | 05/04/2011 |                              |  |
| NAME OF DROWIDER OR CURRY IFD |  |  | D. WIIV |                      | ADDRESS, CITY, STATE, ZIP CODE   |            |                              |  |
| NAME OF PROVIDER OR SUPPLIER  |  |  |         |                      | GRACE ST   |            |                              |  |
| RENSSELAER CARE CENTER        |  |  |         | RENSS                | ELAER, IN47978   |            |                              |  |
| (X4) ID                       | SUMMARY STATEMENT OF DEFICIENCIES  |  |         | ID                   | PROVIDER'S PLAN OF CORRECTION  |            | (X5)                         |  |
| PREFIX<br>TAG                 | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  |         | PREFIX<br>TAG        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ГЕ         | COMPLETION<br>DATE           |  |
| 1710                          | +  | s found sitting on her                               |         | mo                   | ·  |            | DATE                         |  |
|                               |  | the stationary chair. She                            |         |                      |  |            |                              |  |
|                               | 1  | e had gotten up from the                             |         |                      |  |            |                              |  |
|                               | 1  | nething up off the floor.                            |         |                      |  |            |                              |  |
|                               | 1  |  |         |                      |  |            |                              |  |
|                               | The form titled '  | 'Fall Risk Assessment"                               |         |                      |  |            |                              |  |
|                               | was reviewed. T  | he entry, dated 3/8/11,                              |         |                      |  |            |                              |  |
|                               | indicated the res  | ident's fall risk was 22. A                          |         |                      |  |            |                              |  |
|                               | 1  | ored a 10 or higher was at                           |         |                      |  |            |                              |  |
|                               |  | e intervention portion of                            |         |                      |  |            |                              |  |
|                               | the form, dated 3/8/11, indicated, "Scored 22 falls 1/13/11, 2/3/11, 2/13/11. Has    |  |         |                      |  |            |                              |  |
|                               |  |  |         |                      |  |            |                              |  |
|                               | `  | memory) loss/cognitive                               |         |                      |  |            |                              |  |
|                               | 1 ^  | x (history) of behaviors                             |         |                      |  |            |                              |  |
|                               | 1  | Dementia with psychotic                              |         |                      |  |            |                              |  |
|                               | * •  | etful. Has attempts to                               |         |                      |  |            |                              |  |
|                               | 1  | ms off floor. Has bed &                              |         |                      |  |            |                              |  |
|                               | 1  | (bilateral) SR (side rails)                          |         |                      |  |            |                              |  |
|                               | 1  | ippy strips on floor next er. Unable to balance test |         |                      |  |            |                              |  |
|                               |  |  |         |                      |  |            |                              |  |
|                               | 1 .  | assist of 1 with standing wobbly/unsteady."          |         |                      |  |            |                              |  |
|                               | Hallsters - weak   | woodly/unsicady.                                     |         |                      |  |            |                              |  |
|                               | Review of the M  | Iay 2011 Physician Order                             |         |                      |  |            |                              |  |
|                               |  | the resident was to have a                           |         |                      |  |            |                              |  |
|                               | sensory pad to si  | tationary chair.                                     |         |                      |  |            |                              |  |
|                               |  |  |         |                      |  |            |                              |  |
|                               | _  | an, dated 1/7/11, was                                |         |                      |  |            |                              |  |
|                               | reviewed. The ir   | nterventions to decrease                             |         |                      |  |            |                              |  |
|                               | falls included:  |  |         |                      |  |            |                              |  |
|                               | 1 -  | to bed and stationary                                |         |                      |  |            |                              |  |
|                               | 1  | cement and function every                            |         |                      |  |            |                              |  |
|                               | shift  |  |         |                      |  |            |                              |  |
|                               | - grippy strips in   | front of stationary chair,                           |         |                      |  |            |                              |  |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| <b>i</b> '  |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) M<br>A. BUII |   | NSTRUCTION<br>00  | (X3) DATE S<br>COMPL |            |  |
|---|--|--|-------------------|---|---|----------------------|------------|--|
|   |  | 155287   | B. WIN            |   |   | 05/04/2              | 011        |  |
| NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER |  |  |                   | STREET ADDRESS, CITY, STATE, ZIP CODE  1309 E GRACE ST  RENSSELAER, IN47978 |   |                      |            |  |
| (X4) ID   | SUMMARY STATEMENT OF DEFICIENCIES  |  |                   | ID PROVIDENS NAMOS CORRECTION   |   | (X5)                 |            |  |
| PREFIX  | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |                   | PREFIX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                   | COMPLETION |  |
| TAG   |  |  |                   | TAG   | DEFICIENCY)   |                      | DATE       |  |
|   | the intervention was dated 2/13/11   |  |                   |   |   |                      |            |  |
|   | The ADON (Assinursing) was informal interventions in place.  3. Resident #D with 10:00 a.m. The rewident had personal alarm at jacket. During considered to 5/3/11 at 12:55 persident was seat the personal alarm. On 5/4/11 at 8:25 observed seated in dining room. The on and the personal the jacket.  At 12:15 p.m. on seated in the wheel entrance door. Lift attaching the resident's jacket.  Interview with Lift p.m., indicated the out with his son. | istant Director of formed on 5/4/11 that the for the resident were not was observed on 5/3/11 at esident was seated in a ant of the nurses' station. a jacket on. There was a stached to the resident's ontinued observations on .m. and 3:05 p.m., the ed in his wheelchair with m attached to his jacket. So a.m., the resident was in his wheelchair in the expression that had his jacket and alarm was attached to his jacket and his jack |                   |   |   |                      |            |  |
|   | The record for Re  | esident #D was reviewed  |                   |   |   |                      |            |  |

| l ·                          |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287 | A. BUI              | LDING                            | NSTRUCTION  00   | (X3) DATE S<br>COMPL<br>05/04/2 | ETED               |
|------------------------------|---|--|---------------------|----------------------------------|--|---------------------------------|--------------------|
|                              |   |  | B. WIN              |                                  | DDRESS, CITY, STATE, ZIP CODE  | 00/01/2                         |                    |
| NAME OF PROVIDER OR SUPPLIER |   |  |                     | 1                                | GRACE ST   |                                 |                    |
| RENSSE                       | LAER CARE CENT  | ΓER  | RENSSELAER, IN47978 |                                  |  |                                 |                    |
| (X4) ID                      | SUMMARY STATEMENT OF DEFICIENCIES   |  |                     | ID PROVIDER'S PLAN OF CORRECTION |  |                                 | (X5)               |
| PREFIX<br>TAG                | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                  |  |                     | PREFIX<br>TAG                    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE                              | COMPLETION<br>DATE |
| 1710                         | on 5/3/11 at 11:15 a.m. The resident had  |  | +                   | IAG                              | ·  |                                 | DATE               |
|                              |   | cluded, but were not                                     |                     |                                  |  |                                 |                    |
|                              | 1 -   | plood pressure, dementia                                 |                     |                                  |  |                                 |                    |
|                              | with behaviors,   |  |                     |                                  |  |                                 |                    |
|                              |   |  |                     |                                  |  |                                 |                    |
|                              | The form titled '   | 'Fall Risk Assessment"                                   |                     |                                  |  |                                 |                    |
|                              |   | he entry, dated 2/18/11,                                 |                     |                                  |  |                                 |                    |
|                              |   | ident's fall risk was 26, (a                             |                     |                                  |  |                                 |                    |
|                              |   | gher is at risk for falls).                              |                     |                                  |  |                                 |                    |
|                              | The intervention portion of the form,   |  |                     |                                  |  |                                 |                    |
|                              | dated 2/18/11, indicated the resident had a fall on 12/13/10.  Review of the May 2011 physician order |  |                     |                                  |  |                                 |                    |
|                              |   |  |                     |                                  |  |                                 |                    |
|                              |   |  |                     |                                  |  |                                 |                    |
|                              |   | he resident was to have a                                |                     |                                  |  |                                 |                    |
|                              | personal alarm in use while in the  |  |                     |                                  |  |                                 |                    |
|                              | wheelchair.   |  |                     |                                  |  |                                 |                    |
|                              | The fall care pla   | n, dated 12/10/10, was                                   |                     |                                  |  |                                 |                    |
|                              | 1   | are plan indicated the                                   |                     |                                  |  |                                 |                    |
|                              |   | isk for falls related to                                 |                     |                                  |  |                                 |                    |
|                              |   | ity, history of falls,                                   |                     |                                  |  |                                 |                    |
|                              |   | tigo and dementia, with                                  |                     |                                  |  |                                 |                    |
|                              |   | reness. Interventions to                                 |                     |                                  |  |                                 |                    |
|                              | decrease falls in   | cluded:  |                     |                                  |  |                                 |                    |
|                              | - personal alarm  | in wheelchair  |                     |                                  |  |                                 |                    |
|                              | -falling star program - place personal alarm clip on shirt not  |  |                     |                                  |  |                                 |                    |
|                              |   |  |                     |                                  |  |                                 |                    |
|                              | jacket due to res   | ident removes jacket                                     |                     |                                  |  |                                 |                    |
|                              | The ADON (Ass   | sistant Director of                                      |                     |                                  |  |                                 |                    |
|                              | `   | formed on 5/4/11 at 12:30                                |                     |                                  |  |                                 |                    |
|                              | 1   | nt's personal alarm was                                  |                     |                                  |  |                                 |                    |
|                              | 1 ~   | ncket on 5/3/11 and 5/4/11                               |                     |                                  |  |                                 |                    |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287 |                                 | (X2) MULTIPLE CO  A. BUILDING  B. WING  | 00                  | COM<br>05/04   | e survey<br>pleted<br>/2011 |                            |
|--|---------------------------------|---|---------------------|--|-----------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER  |                                 |   | 1309 E              | ADDRESS, CITY, STATE, ZIP<br>GRACE ST<br>SELAER, IN47978                                   | CODE                        |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN                  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
|  | and not to his shiplan of care. | irt, as indicated on the  |                     |  |                             |                            |
|  | 3.1-45(a)(2)                    |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |
|  |                                 |   |                     |  |                             |                            |